

Behavioral Health Work Groups

Final Report

August 2011

Background: In June, 2010 the West Virginia Health Improvement Institute (WVHII) hosted a summit of stakeholders of the Behavioral Health communities in West Virginia. The purpose of this effort was , in part, preparation for an anticipated transition to a managed care system to replace the current system. State agencies, medical and behavioral health providers, advocacy organizations, professional societies, trade organizations, consultants, court monitors, lobbyists and consumers convened to discuss collaborative opportunities and ways to improve the quality of behavioral health services for West Virginians. There were several needs identified by the participants. The first was the need for a model of integration of behavioral health and primary care that could serve as a guide for West Virginia. A second need was to reach a consensus of measures of quality for behavioral health that would reflect integration of primary care and behavioral health. A third need was to foster alignment across payers, the delivery system and the state to drive administrative simplification as much as possible.

Three work groups met from June 2010 until the end of the year. A series of conference calls and meetings between the Bureau for Medical Services and payers resulted in streamlining of some of the credentialing, reporting and pre-authorization processes to support behavioral health services in a managed care environment. A model for integration of behavioral health and primary care was developed. Finally, consensus was reached on a set of measures of quality for behavioral health. This report summarizes these work products. Section 1 provides the Behavioral Health Model in the form of a White Paper. Section 2 provides the core measures.

Section 1

Model for Integration of Behavioral Health and Primary Care Developed by the Behavioral Health Integration Model Work Group

Background: In June, 2010 the West Virginia Health Improvement Institute (WVHII) hosted a summit of stakeholders of the Behavioral Health system in West Virginia. State agencies, medical and behavioral health providers, advocacy organizations, professional societies, trade organizations, consultants, court monitors, lobbyists and consumers convened to discuss collaborative opportunities and ways to improve the quality of behavioral health services for West Virginians. The participants identified the need for a model of integration of behavioral health and primary care that could serve as a guide for West Virginia. A work group was established and they spent the fall of 2010 developing a model.

Problem Statement: People with behavioral health issues often receive substandard care due to the fragmentation of the health care system and the lack of integration and coordination across the continuum of care. As a result, a person with severe mental health disorders, on average, would be expected to live 25 years less than someone without severe mental health diseases. Most often, these individuals succumb to health issues that might have been addressed had the person received evidence-based, age appropriate preventive and chronic disease management. Conversely, patients treated in a primary care setting that experience behavioral health issues often do not receive adequate care management for their behavioral health problems. The inability to address behavioral health issues for those with a chronic disease leads to a lack of adherence to treatment plans and medications, increased inefficiency in the treatment of the disease and a compounding of the health-related challenges impacting the patient.

AIM: The aim of this white paper is to set forth a model for the integration of primary care and behavioral health that improves health care for all West Virginians. The model is intended to establish a set of design principles for the integration of behavioral health and primary care in order to guide providers, payers and state agencies in the design and support of health care services. It is recognized that there are many gaps between the current state of services and the proposed model. Through future and ongoing collaborations it is the vision of the Behavioral Health Integration Model Work Group to bridge these gaps in care delivery in order to improve the health and wellbeing of all West Virginians

Model of Care: There are many challenges associated with crafting a model for integration of primary care and behavioral health. In part this is due to the range of illnesses and disorders addressed within both primary care and behavioral health. The history of integration of the two disciplines has been varied with most serious behavioral health challenges being addressed in a behavioral health setting and most primary care issues being addressed in a primary care setting. One model endorsed by the Behavioral Health Work Group is a model that also has national endorsement by many of the Behavioral Health professional organizations. The model is presented in Figure 1.¹

¹ Adapted from Minkoff, Kevin. Dual Diagnosis: an integrated model for the treatment of people with co-occurring psychiatric and substance abuse disorders in managed care systems. Presented to the National Council for Community Behavioral healthcare Conference, March 2002.

behavioral health and physical health needs. These patients may be institutionalized, suggesting that the health care team caring for that patient may need to have a high degree of coordination/integration of primary care for the management of the chronic medical conditions of the patient.

This white paper is not an endorsement of any payment mechanism, such as capitated managed care or fee for service, nor does this paper indicate the support or opposition to risk transference on the part of the state or any payer to an HMO or other payer. This paper is only a discussion on integration and is not a discussion on financing mechanisms to support integration. Those who developed this model recognize the need for further discussions on how the system is built and financed.

Case Study Examples:

The importance of integration of behavioral health and primary care can best be understood through case studies. The following scenarios are drawn from true patient experiences and are intended to demonstrate the role coordination and integration of services can play in improving health care management and systems.

Case Study: Patient with behavioral health issues referred to Behavioral Health Professional in Ambulatory Setting

A 74 -year old male presented with severe depression and suicidal ideation with an active plan. He complained of excessive, daytime drowsiness and non-restorative sleep. He declined psychiatric hospitalization and antidepressant treatment. An urgent overnight sleep study was obtained. The findings revealed Obstructive Sleep Apnea (OSA). The patient was started on CPAP with good compliance. The suicidal ideation and depression resolved rapidly. Symptoms remained in remission 4 months later upon follow- up.

Case Study: Adolescent in primary care referred to in-house health psychologist for depression

A 13 -year old presented with moderate depression; moderate anxiety; chronic daily headaches and daytime fatigue. During the course of the assessment, the patient revealed that she was achieving less than 4 hours of sleep per night as a result of the 9 dogs in her bedroom, and the lack of a door. In addition, there were gasoline fumes, on the floor from a spill during an uncompleted remodeling of the room, that were further irritating her. The interventions included: installation of a door to keep the dogs out and cleaning up the floor area with the gas spill residue. A one month follow-up revealed that the depression, anxiety, headaches, and daytime fatigue were all in remission.

Examples of Models for Integration:

The prevalent model in West Virginia is one of informal referral relationships where primary care providers refer patients to behavioral health resources in the local community on an “as needed basis.” Routine screening for serious behavioral health issues is not prevalent throughout the primary care system. Conversely, patients in specialty behavioral health facilities also rely on informal referral sources when a physical health issues arises for seriously mentally ill institutionalized or domiciled patients.

The following are examples of emerging models to improve integration of behavioral health and primary care:

Formal Referral Relationships: Under such a relationship a formal memorandum of understanding (MOU) or contractual relationship is in place that provides direct linkage to behavioral health resources in primary care or primary care resources in a behavioral health setting. Examples of such relationships include:

Primary Care: Wort County is an example of tight integration where behavioral health providers work closely with primary care providers through formal referral relationships under a rural health network model focused on improving access and quality of care.

Behavioral Health: Valley Community Health Center (VCHC) began as a formal relationship with Presteria in Huntington, cross referring patients based on their primary care and behavioral health needs. That relationship is evolving into a co-location model (description below) where a new primary care clinic broke ground in August, 2011 being built adjacent to comprehensive behavioral health services. The co-location will allow for further integration of those previously informal relationships.

Co-Location: Another model involves co-location of services provided by independent organizational entities, but by virtue of their co-location present ready access to behavioral health consultative services and primary care consultative services. Holyoke Community Health Center (HCHC) (a Federally Qualified Health Center (FQHC) in Massachusetts) shares space with Behavioral Health Network (BHN), a community based mental health provider. When a behavioral health issue arises with a patient, a warm handoff can be achieved with a behavioral health provider whose office is a corridor away. Conversely, a primary care issue identified in the course of a behavioral health visit can be addressed in real time through a warm handoff. Examples in West Virginia include:

Primary Care: Shenandoah Community Health Center (SCHC) established a behavioral health service as part of its Federally Qualified Health Center. The service operates as a separate clinical unit, but affords the opportunity for patients to be seen in the primary care setting by a behavioral health provider at the point of service, in the behavioral health unit immediately following the primary care visit or at another future point in time. Behavioral health providers bill under separate provider numbers for these services.

Behavioral Health: Valley Community Behavioral Health Care (VCBHC) has a clinic where primary care providers are on site two days a week in a co-location model where they operate as a separate service and bill under separate provider numbers but collaborate to ensure that the primary care needs and behavioral health needs of their patients are served concurrently.

Mildred Mitchell-Bateman Hospital (Bateman Hospital), a 90- bed psychiatric hospital in Huntington, has a fulltime primary care provider on staff serving the long -term residents. Upon admission each patient receives a complete medical history and examination and a psychiatric evaluation within 24 hours of admission. In addition, non-psychiatric medical needs are also addressed through the services of the Family Practice Clinic (FPC) operated on the hospital grounds by physicians from Marshall University (MU).

Partial Integration: A partial integrative model is one in which behavioral health resources are located onsite and can be integrated into the care delivery model through warm and seamless handoffs. The Screening, Brief Intervention, Referral, Intervention and Treatment (SBIRT) program in West Virginia provides a behavioral health resource for onsite screening, brief intervention and referral to broader subspecialty resources as needed. The Health Resources Services Administration (HRSA) has recently provided expansion resources for FQHCs to add behavioral health services onsite. Examples in West Virginia include:

Cabin Creek Community Health Center: Cabin Creek, an FQHC, has one fulltime equivalent (FTE) clinical social worker at each of its two sites (one of these is school based program with two schools) and shares one and two tenths of a fulltime equivalent psychologist at the other two CHC sites. The behavioral health consultants work in the same area as the medical providers, are available for quick handoffs and provide a wide range of services - from motivational interviewing for patients with chronic conditions to counseling and monitoring of symptoms of patients with psychoses. In addition, they have a visiting psychiatrist (.2 FTE) who provides some onsite services and telemedicine support. The web- based EMR facilitates communication with the offsite psychiatrist. In addition, a visiting adolescent medicine specialist (with WVU Pediatrics) provides a large amount of behavioral health services for adolescents in two schools served by Cabin Creek and collaborates closely with a clinical social worker. Electronic medical records are shared and registries imbedded in the Cabin Creek EMR are used for chronic pain patients who must be evaluated by a Behavioral Health Counselor (BHC) and for Attention Deficit Hyperactivity Disorder (ADHD) patients. These collaborative communication efforts allow for tracking key clinical standards. Cabin Creek has provided extensive training to all BHCs in motivational interviewing and training in Acceptance Commitment Therapy (ACT).

Fully Integrated Care Model: A fully- integrated model includes the use of a multi-disciplinary care team functioning as a true medical home supported by subspecialty services and community- based resources. This model differs from a co-location model in that the services are fully integrated as a single ~~model~~ service entity rather than simply coordinating between two independent services (e.g. behavioral health and primary care). A model for such integration nationally is the South Central Foundation (SCF) in Anchorage, Alaska. The multi-disciplinary care team is co-located in a pod comprised of a primary care provider, an advanced practice professional, a pharmacist, a dietician, a medical assistant, a nurse and a behaviorist. The behaviorist's role is to do routine screening for behavioral health issues and to provide brief, behavioral health, self-management coaching through the use of motivational interviewing and shared goal setting techniques. Issues that cannot be addressed within two 20- minute primary care consultations are subsequently referred to a Psychiatrist or Psychologist who is co-located in the same facility and readily accessible to the primary care team. The care team serves as the true medical home by coordinating care across the continuum of services. The care team has established community- based resources that are extenders of the care team who work closely with the team on a referral basis. The care team continues to manage the health care needs of the patient across the spectrum of care. Clinica Family Health Services in Lafayette, Colorado contracts for behavioral health specialists onsite, on a fulltime basis, working as part of an integrated care team. This model of partnership has led to a truly integrated model with rapid access to subspecialty services in a behavioral health setting.

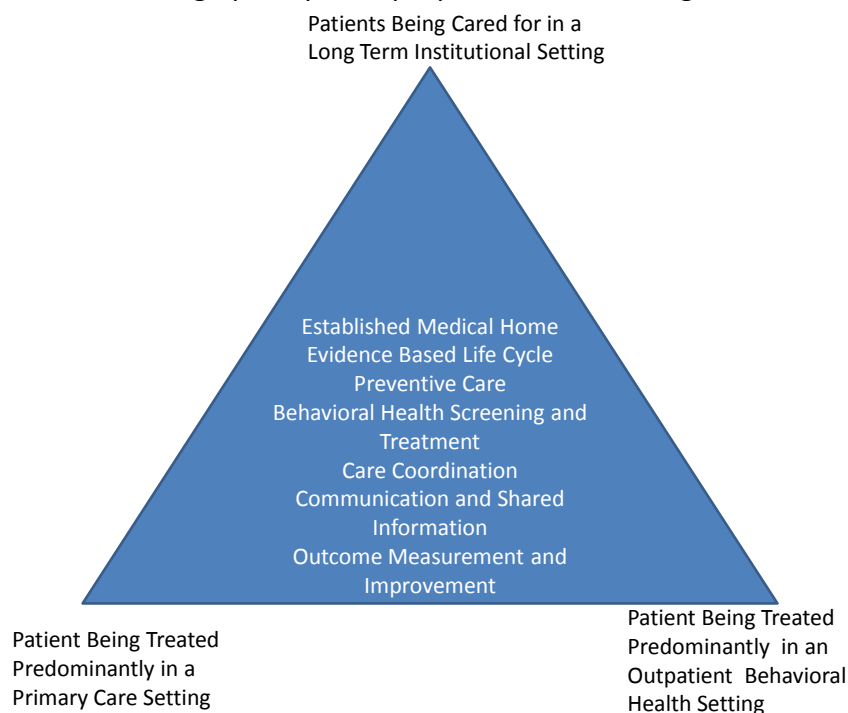
In a behavioral health setting a fully-integrated care model would have primary care services onsite for institutionalized patients or those managed by the behavioral health center. Under such a model, the primary care provider would participate in shared care planning for the health care needs for the population of patients served and act as a team member in the integrated the day- to- day care and management support of the patients.

The West Virginia Model for Integration:

The American Association of Community Psychiatrists (AACCP) has recommended that behavioral healthcare providers at the local level incorporate a systematic program for coordinating or integrating with primary care provider organizations in their communities in order to improve quality of care and reduce health care costs. Such a program would include, at a minimum:

- Effective means of bi-directional communications with Primary Care Providers (PCPs);
- Determination of what information is most essential to share; and,
- Adoption of appropriate confidentiality and consent protocols

The following model and core set of design principles is proposed for West Virginia.



It is recognized that West Virginia faces many challenges as a rural state. As a result, the ultimate model of integration will be dependent upon the availability of providers in the local community. However, all models of integration should share certain design principles.

Design Principles of the Model:

The following design principles should guide the integration of services for the population:

- Every person should have a clearly defined **patient centered medical home** that is responsible for coordination of care for the patient and family. The patient centered medical home should be clearly known to the patient and family and acknowledged by the health care providers assuming that responsibility
- Care should be **patient centric** and oriented to where the patient most frequently seeks their care; also it is the responsibility of the care system to ensure integration and coordination of services on behalf of the patient and family
- The system should be **holistic** in its approach addressing the physical, behavioral, spiritual and social needs of the person. This should include routine screening for behavioral health issues in the primary care setting, as well as, appropriate evidence- based, preventive and chronic care management for those patients in a behavioral health setting
- A core set of **integrated measures** of health should be routinely tracked to ensure that patients are receiving the care needed
- The system should result in improved outcomes, lower global cost and improved experience of care for the patient, family and care team (**Triple Aim**)
- **Health Information Technology** should be used to ensure that health information is shared by the collective care team to improve health outcomes
- The **reimbursement** system should evolve to support payment models that **encourage integration** of services and optimal care coordination

Gaps between the current system and the model:

The model put forth in this paper reflects more of an idealized design rather than the current state of the health care system in West Virginia. In order to move closer to this idealized design there are gaps and barriers in the current system to be overcome. These include:

- **Cultural stigma:** There remain cultural stigma issues that influence both patient choice and delivery design. Fear of the stigma associated with behavioral health can influence where patients seek services. For example, a patient may purposely not seek integrated services with their own primary care services provider for fear that a neighbor in a primary care waiting room might become aware that one is being treated for depression. The challenges of patient confidentiality and privacy considerations also often drive the health care system to evolve as separate services
- **Patient Management Challenges:** Often the co-morbidities and complexities of illness of the patients make it difficult for their care to be provided in a particular setting. For example, a consumer with severe schizophrenia and sociopathic tendencies might be difficult to treat in a traditional primary care setting where the impact of behaviors on other primary care patients would be challenging to manage.

Conversely, a ~~severely~~ seriously mentally ill patient in an institutional setting with a chronic disease might best be treated in that institutional setting, instead of elsewhere

- **Legal system:** Privacy and security concerns relative to patient information have resulted in the establishment of very stringent guidelines and a legal framework that produces great reluctance to share health information. As health information exchanges evolve and more of these policies and protections become mainstreamed, the perceived legal barriers will need to be overcome through education of both the provider and consumer communities
- **Supply and work force issues:** There are supply issues for both primary care and behavioral health providers in West Virginia. This suggests an even greater importance for closer coordination and collaboration of services, as well as, alternative models for service delivery, such as the use of telemedicine
- **Reimbursement:** There remain reimbursement issues that present challenges. The inability to charge for behavioral health services on the same day as a primary care service in many instances discourages warm handoffs of patients who require both services. Rates for behavioral health services in the ambulatory care setting have remained at the same level for many years. The reimbursement system also has not historically supported care coordination, health education and behavioral health screening in the primary care setting. Social services traditionally supported in the behavioral health environment that are necessary to keep patients out of long-term facilities, might not be deemed medically necessary because these resources are not traditionally supported as medical services
- **Measuring health care quality:** There have not been well-established measures of quality and treatment outcomes tracked across the continuum of primary care and behavioral health that reflect the impact of integration. Many behavioral health measures are also dependent upon administrative data (e.g. claims) which by definition have a time lag in terms data availability. The Substance Abuse and Mental Health Services Administration (SAMHSA) measures have typically been collected in comprehensive behavioral health centers, but not fully deployed in behavioral health private practice ambulatory settings
- **Licensure:** There remains controversy over the licensure of certain health professionals, such as counselors and support staff. The requirement for licensure may limit the ability to be reimbursed for guidance and help from such professionals
- **Training of health professionals:** Health professional training will need to be adapted to reinforce the integration of behavioral health and primary care at the undergraduate and graduate training levels. This is especially true relative to screening, basic tools in the primary care setting and mechanisms to facilitate integration and coordination across the continuum of care
- **Re-Training of Providers:** There will be a need to train existing health professionals in order for the new model to become widely deployed and practiced. Training is often difficult to orchestrate without financial support for the lost time and clinical productivity

Implications for Key Stakeholders:

A model for integration presents both adaptive challenges and opportunities for stakeholders: The benefit of a model is that it can inform the design properties of the health care system that needs to change and evolve in order to improve the quality of services. The following are examples of some of those opportunities and actionable guidance:

Primary Care Providers:

- Embrace the patient centered health care home model and implement the practice changes necessary to serve as a true medical home
- Train staff in appropriate core behavioral health skills that improve the management of health care (e.g. in the screening and assessment for behavioral health issues; use of motivational interviewing techniques, such as the Stanford Chronic Disease Management Program etc.)
- Systematically screen the primary care population for behavioral health issues
- Establish formal, referral relationships with behavioral health providers to meet the health care needs of the panel of patients being supported as medical homes
- Blur the organizational boundaries and engage community- based organizations and referral sources in order to foster a multi-disciplinary care model that meets the needs of the population
- Evolve toward an integrated care model and multi-disciplinary care team
- Create mechanisms for behavioral health team members to participate and contribute to shared care planning
- Adapt information systems and supporting administrative processes and policies so that information can be shared among disparate providers caring for the needs of patients
- Engage as early adopters of health information exchange to ensure that information is flowing across the health care system to meet the care needs of the population
- Measure, report and improve outcome and processes associated with the behavioral needs of the patient
- Study and document the business case for quality integrated health care in order to further influence stakeholders in the transformation process
- Participate in training on the new emerging model of integration
- Participate in demonstration programs on the new model

Behavioral Health Care Providers:

- ~~Confirm~~ Ensure and document the a patient centered health care home for every person cared for by behavioral health providers; ensure that the person being treated is aware of that medical home relationship; understands the need for sharing of information and consents to such sharing in a secure manner
- Ensure that information is shared in a secure, confidential manner that meets the intent of the minimal information on an “as need to know basis”
- Share information with the primary care medical home that informs patient care decision making while optimizing services and resources
- Collaborate in shared care planning and decision making
- For patients in long- term care facilities, ensure that every patient receives age appropriate, evidence-based prevention care and chronic disease management with shared care planning
- Adapt information systems and supporting administrative processes and policies so that information can be shared across disparate providers caring for the needs of patients
- Engage as early adopters of health information exchange to ensure that information is flowing across the health care system to meet the care needs of the population

- Measure, report and improve outcome and processes associated with the primary care health needs of the patient
- Study and document the business case for quality, integrated health care in order to further influence stakeholders in the transformation process
- Participate in training on the new emerging model of integration and participate in demonstration programs on the new model

Payers and Managed Care Organizations:

- Ensure that every beneficiary has a clearly defined patient centered health care home; that the patient and provider are aware of their relationship; and that the managed care organization works to support that relationship
- Make process and outcome (quality and cost) data available to the health care team for the purpose of improving quality
- Use population health tools (e.g. risk screening and stratification tools) to identify patients at risk or high utilizers and engage the multi-disciplinary care team on ways to improve the health status of that individual
- Provide care coordination support to primary care and behavioral health providers where economies of scale to enable such support are not cost effective at the point of service
- Support reimbursement models that encourage integration of behavioral health and primary care services. These models should include clarification of both medical and behavioral health necessities in order to highlight the interactive impact of these areas and the ability to move consumers to less costly treatment settings (e.g. by including social services as part of treatment support in order move patients from a high cost institutional setting to a community based setting)
- Provide support for quality improvement initiatives, pilots and demonstration programs focused on improving quality
- Educate members about the medical home model and integrated behavioral health and their role in driving improved health outcomes
- Support and promote training opportunities for health professionals on the new models of integration

State:

- Ensure that every beneficiary has a clearly defined patient centered health care home, that the patient and provider is aware of that relationships and the managed care organization works to support that relationship
- Make process and outcome (quality and cost) data available to the health care team for the purpose of improving quality
- Use population health tools (e.g. risk screening and stratification tools) to identify patients at risk or high utilizers and engage the multi-disciplinary care team to improve the health status of the individual
- Provide care coordination support to primary care and behavioral health providers where economies of scale to enable such support are not cost effective at the point of service
- Support reimbursement models that encourage integration of behavioral health and primary care services, including clarification of both medical and behavioral health necessity, clarifying the interactive impact of these areas

- Provide support for quality improvement initiatives, pilots and demonstration programs focused on improving quality
- Ensure that primary care and behavioral health measures are collected and shared, tracking the progress of improvement in the quality of health care services provided to West Virginians
- Provide support for pilots and demonstration programs on innovative programs to integrate services and improve the quality of health care for all beneficiaries
- Strive to identify and remove barriers that preclude effective care delivery and integration of services where the evidence- base exists to offer a pathway for such programmatic or benefit design changes
- Create and sustain vehicles for on-going input to the improvement process for providers, payers, advocacy organizations and patients and families
- Improve data collection systems and foster interoperability of information from the Medicaid program that enhances patient care and guides improvement efforts
- Facilitate opportunities for relationship building between the primary care system and behavioral health organization in order to connect resources that lead to enhanced care delivery
- Support and promote training opportunities for health professionals on the new models of integration

Community Based Organizations:

- Promote evidence- based models that foster self -management capacity building and personal responsibility
- Collaborate with behavioral health and primary care teams to augment services not economically viable in the outpatient setting
- Strive to develop models for virtual integration that provide a continuum of support services through shared information systems, review and analysis of data and joint care planning
- Provide care coordination support to primary care and behavioral health providers where economies of scale to enable such support are not cost effective at the point of service

Health Information Exchange:

- Ensure Continuity of Care Document applications and Continuity of Care Record applications evolve with integrated behavioral health and primary care needs in mind
- Promote use cases of data sharing between the behavioral health and primary care communities
- Foster telemedicine opportunities between behavioral health and primary care to expand access to care through the health information exchange

Consumers:

- Ensure that every consumer understands their medical home provider resources
- Ensure that the medical home provider has established formal relationships that guarantee that a continuum of services will be available to meet the primary care and behavioral health service needs of the patient

Advocacy Organizations:

- Educate the public about the integration model and the need for integration; and the role the model plays in a patient centric medical home environment
- Teach the public about mechanisms for privacy and security and about the positive benefits of exchange of health information

Summary

The Behavioral Health Model for Integration provides a roadmap of design principles that key stakeholders should strive to implement and adhere to in their efforts to collaborate on improving the health of all West Virginians.

This white paper was developed as a result of the efforts of stakeholders from across the health care system collaborating to improve the health of all West Virginians. The paper was widely circulated for comment and feedback prior to finalization. An electronic copy of this paper can be found on the West Virginia Health Improvement Institute at www.wvhealthimprovement.org. Questions may be directed to the lead author for this paper, Roger Chaufourier at webmaster@wvhealthimprovement.org.

Glossary of Terms

The following glossary of terms is adapted from SAMHSA from their web site:
<http://systemsofcare.samhsa.gov/ResourceGuide/glossary.html>

Glossary of Key Terms

- **Administrators:** Individuals that manage agency functions related to service delivery, training, human resources, financing, management information systems, and quality improvement.
- **Aggression:** Words and actions that are deemed to be threatening to others.
- **Anxiety:** Exaggerated or inappropriate responses to the perception of internal or external dangers. Includes panic disorders, phobias, obsessive-compulsive disorders, post-traumatic stress, and generalized anxiety disorders.¹
- **Assessment:** A professional review of child and family needs that is done when services are first sought or periodically to assess progress. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the provider and family decide what kind of treatment and supports, if any, are needed.²
- **Assessment protocol:** a set of guidelines that an agency or individual follows when conducting assessments.
- **Assessment tools:** A variety of standardized instruments that are used to gather information about a person's functioning and/or level of need.
- **Attribute:** An inherent quality or characteristic.³
- **Behavioral healthcare:** Continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.²
- **Behavioral therapy:** As the name implies, behavioral therapy focuses on changing unwanted behaviors through rewards, reinforcements, and desensitization. Behavioral therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behavior.⁴
- **Best practices:** Most often is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not necessarily include systematic use of available research evidence.⁵
- **Biopsychosocial assessment:** The evaluation of a person's biological, psychological, and social factors to develop a comprehensive picture from which to base treatment.
- **Case manager:** An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)²
- **Capacity building:** Involves enhancing the ability of individuals, groups, organizations, and systems to mobilize and develop resources, skills and commitments needed to accomplish shared goals.⁶
- **Child and Adolescent Functional Assessment Scale (CAFAS):** is a rating scale, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.²
- **Child welfare:** Child service sector that focuses on child protection, foster care, and the overall care of children's health and living conditions.
- **Cognitive therapy:** Aims to identify and correct distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behavior.⁴
- **Cognitive behavioral therapy:** A combination of cognitive and behavioral therapies which helps people change negative thought patterns, beliefs, and behaviors so they can manage symptoms and enjoy more productive, less stressful lives.⁴
- **Community capacity:** Refers to the ability of community members to use the assets of its residents, associations and institutions to improve quality of life. Each community's collection of assets will be unique, for it will reflect the specific characteristics of its population, its political structures and geography.⁶
- **Conduct Problems:** Behaviors that are characterized by acting out, ranging from annoying, minor oppositional behavior (yelling, temper tantrums) to more serious types of antisocial behavior (aggression, physical destruction, stealing).³
- **Consumer:** Any individual who does or could receive health care or services. Includes other more specialized terms, such as beneficiary, client, customer, eligible member, recipient, or patient.²
- **Continuous Quality Improvement:** A strategy of continuously assessing the process and outcomes of service delivery to learn how to improve those processes to reach better outcomes and higher quality of mental health care.²²
- **Cultural Competence:** Understanding and appreciating the differences in individuals, families, and communities, which can include: thoughts, speech, actions, customary beliefs, social forms and material traits of a racial, religious or social group. It also affects age, national origin, gender, sexual orientation or physical disability. ⁹

- **Depression:** A type of mood disorder characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time.¹
- **Diagnosis/Diagnostic Formulation:** The process of determining by examination the nature and circumstances of a mental health condition and the decision reached by such examination.¹⁰
- **Early Intervention:** A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.¹¹
- **Emerging Practices:** Are new innovations in clinical or administrative practice that address critical needs of a particular program, population or system, but do not yet have scientific or broad expert consensus support.⁵
- **Emotional Health:** The well-being and appropriate expressions of one's emotions.
- **Evidence:** Refers to data resulting from scientific controlled trials and research, expert or user consensus, evaluation, or anecdotal information.⁵
- **Evidence-Based Assessment:** Methods and processes that are based on empirical evidence, in terms of both reliability and validity as well as their clinical usefulness for prescribed populations and purposes.¹²
- **Evidence-Based Care:** The application of the best evidence available to treat in the health care community to improve the overall quality of care.
- **Evidence-Based Culture:** Characteristics or features of organizations and systems that support the use of EBPs.
- **Evidence-Based Environment:** An environment in health care that is represented by the practice and implementation of evidence-based interventions.
- **Evidence-Based Practices:** Practices that integrate the best research evidence with clinical expertise and patient values.¹³
- **Externalizing Disorder:** Disorders that are expressed overtly and can be characterized by aggression, behavioral acting-out, hyperactivity, and conduct disorder.
- **Family-Centered Services:** Help designed to meet the specific needs of each individual child and family.²
- **Family-Driven:** Families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.¹⁴
- **Family-Run Organizations:** Advocacy and support organizations that are led by family members with expertise/experience in the field of mental health.
- **Fidelity:** Adherence to the key elements of an evidence-based practice shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes.⁵
- **Fidelity Scale:** Measurement instrument for assessing the extent to which information is delivered with fidelity.
- **Financial Readiness:** The assessment of an organization, agency, or individual practice to determine the financial standing and ability to provide evidence-based practices.
- **Hyperactivity:** A disorder in which children are overactive and impulsive (acts without thinking).
- **Internalizing Disorders:** Disorders expressed within the individual and focused on clinically problematic affective and emotional state, such as anxiety or depression.
- **Juvenile Justice:** An area of law that applies to children who have not reached the legal age of adulthood/maturity, normally eighteen years of age. The goal of juvenile justice is rehabilitation, not punishment. Also refers to the service sector that is responsible for serving children judged to have committed unlawful acts.
- **Juvenile Justice Counselor:** Juvenile Counselors provide custody, supervision, direct care, and counseling to juveniles. Responsibilities include teaching socially desired habits and behaviors, provide recreational activities, and assist with crisis intervention programs.¹⁵
- **Licensed Clinical Social Worker:** A social worker who helps individuals deal with a variety of mental health and daily living problems to improve overall functioning. A social worker usually has a master's degree in social work and has studied sociology, growth and development, mental health theory and practice, human behavior/social environment, psychology, research methods.¹⁶
- **Linguistic Competence:** Capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. This may include the use of bilingual staff, interpretation services, assistive technology, etc.¹⁷
- **Manualized Treatment Protocols:** Approaches to mental health treatment that offer a prescriptive approach through the use of manuals and specialized training. These manuals should be followed as stated.
- **Medicaid:** A federal program administered by states that is intended to provide funding for health care and health-related services to low-income individuals or other special groups.
- **Mental Health:** How people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.²
- **Motivational readiness:** The perceived need for improvement or pressure for change.
- **Multisystemic Therapy:** An intensive family- and community-based, evidence-based treatment for youths with antisocial behaviors.

- **Needs Assessment:** Systematic approach for gathering data on the needs of a population to be served.
- **Organizational Readiness Assessment:** Assesses key characteristics that are necessary for implementing an evidence-based practice with new requirements for training, supervision, and measuring fidelity and outcomes.
- **Outcome-Driven Framework:** A guiding set of principles that individuals who are offering mental health services follow when making decisions about treatment. The focus is on the outcomes that need to be achieved.
- **Outcomes:** The results of a specific mental health care service, usually phrased in terms of child and family gains (e.g., improved school performance, improved family communication).²
- **Person-Centered Care:** The recipient of care is the driving force behind making decisions about their treatment.
- **Post-Traumatic Stress Disorder:** A psychiatric illness that can occur following a traumatic event in which there was threat of injury or death to you or someone else.¹⁸
- **Practice-Based Evidence:** A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural of the local society and traditions.¹⁹
- **Practitioner:** Anyone who provides direct services for children or their families. A practitioner may be a licensed independently practicing clinician, a supervised clinical staff member, a certified direct service provider, a person who is trained and meets the criteria to provide direct services or a peer helper.⁵
- **Professional Counselor:** A person with an advanced degree in mental health or other social services charged with assessment and treatment.
- **Prognosis:** Prediction by a health professional regarding a person's diagnosed condition and chances for recovery.
- **Promising Practices:** Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.³
- **Psychiatrist:** A professional who completed both medical school and training in psychiatry and is a specialist in diagnosing and treating mental illness.²
- **Psychologist:** In West Virginia: A professional with a graduate doctoral degree in psychology who is independently licensed in the state where he or she practices and who specializes in assessment and therapy.²
- **Psychopharmacology:** The practice of using medicine to treat individuals with psychological and psychiatric conditions through the use of medications.
- **Psychotherapist:** An individual with an advanced degree in social services charged with assessment and treatment (see *professional counselor*).
- **Reimbursement:** Refunds for out-of-pocket expenses by an individual or company.
- **Resiliency:** The quality that allows an individual or group to function well despite the odds against them. Two fundamental concepts are associated with resiliency: risk and protective factors. Mental health promotion concepts focus on minimizing the impact of risk factors (such as stressful life events) and enhancing the protective factors such as social support that increase people's ability to deal with life's challenges.⁶
- **School psychologist:** An individual with an advanced degree in psychology who assesses children for the presence of learning problems, as well as emotional problems, diagnoses, and treats children in the school system. Roles of school psychologists will vary by location.
- **Scientific Evidence:** Results from a study or research project that has a rigorous controlled design (including a clearly articulated hypothesis and rigorous methodology along with controlled conditions and random assignments to various comparison conditions) that includes sufficient subjects to overcome the possibility that the result could have occurred by chance, and is repeated with the same result in multiple sites with different researchers and different experimental and control groups.⁵
- **Screening instruments:** Typically a brief measure to determine a client's level of need for treatment.
- **Service provider organizations:** Mental health or other social service agencies that offer treatment or other services to children and families.
- **Service system:** Refers to multiple agencies in different sectors (mental health, child welfare, juvenile justice, substance abuse, education, and healthcare) that provide services and treatments for the varying needs of children and families.
- **Social health:** Social health refers to how well you get along with others. When you are socially healthy, you have loving relationships, respect the rights of others, and give and accept help. Building healthy relationships with family members, making and keeping friends, and communicating your needs to others are all important for social health.²⁰
- **Stakeholders:** Those people who are interested, involved, and invested in the project or initiative in some way. In mental health, groups of people who might be identified as stakeholders may be: children and families, family organizations, advocates, community groups, funders, mental health and social service providers, or university or college-based research teams.⁵
- **System of Care:** A system of care is a method of addressing children's mental health needs. It is developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around the principles of being child-centered, family-driven, strength-based, and culturally competent; and involving interagency collaboration.²

- **Wraparound Services:** a collaborative, team-based approach to offering services for children with emotional and behavioral problems and their families. Team members, who are identified by the child and family and other service providers meet regularly to design, implement, and monitor their individualized treatment plans.²¹
- **Youth guided:** Youth are experts and considered equal partners in creating system change at the individual, state, and national level.²

¹ Westchester Community Network. (2005). *Alphabet Soup*. Retrieved October 23, 2006, from http://www.westchestercommunitynetwork.com/Family_Ties/Facts_Information/Alphabet_Soup/alphabet_soup.html

² SAMHSA's National Mental Health Information Center: Center for Mental Health Services. (n.d.) *Mental Health Dictionary*. Retrieved October 23, 2006 from <http://mentalhealth.samhsa.gov/resources/dictionary.aspx>

³ English-Test.net. (n.d.) *Definition of Attribute*. Retrieved October 23, 2006 from <http://www.english-test.net/toefl/vocabulary/words/009/toefl-definitions.php>

⁴ Online Therapy, Counseling & Mental Health Resources. (n.d.). *Glossary of terms commonly used in mental health*. Retrieved October 23, 2006 from <http://www.counselingresource.com/types/glossary/c.html>.

⁵ Hyde, P.S., Falls, K., Morris, J.A., Schoenwald, S.K., (2001). *Turning knowledge into practice: a manual for behavioral health administrators and practitioners about understanding and implementing evidence-based practices*. Boston: Technical Assistance Collaborative.

⁶ Mental Health Promotion Toolkit: A practical resource for community initiatives. (n.d.) *Glossary of terms*. Retrieved October 23, 2006 from http://www.cmha.ca/mh_toolkit/intro/glossary.htm.

⁷ CAFAS. (n.d.) *CAFAS*. Retrieved October 23, 2006 from <http://www.cafas.com>

⁸ McMahon, R.J., Wells, K.C., & Kotler, J.S. (2005). Conduct problems. In E.J. Mash, & Barkley, R.A. (Eds.) *Treatments of childhood disorders: Third edition*. (pp. 137-268). New York: Guilford Press.

⁹ Children's Board of Hillsborough County. (n.d.) *THINK Key Terms, Acronyms and Abbreviations*. Retrieved October 23, 2006 from <http://www.childrensboard.org/familyresources/documents/KeyTermsandAcronyms.pdf>

¹⁰ Dictionary.com. (n.d.) *Definitions from Dictionary.com*. Retrieved October 24, 2006 from <http://www.dictionary.com>.

¹¹ Family Guide: Keeping Youth Mentally Healthy and Drug Free. (n.d.) *Mental Health Dictionary*. Retrieved October 23, 2006 from <http://www.family.samhsa.gov/main/mhdictionary/e.aspx#1>.

¹² Mash, E.J., & Hunsely, J. (2005). Evidence-Based assessment of child and adolescent disorders: issues and challenges. *Journal of Clinical Psychology, 34*(3), 362-379.

¹³ Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st Century*. Washington, D.C., National Academies Press.

¹⁴ Federation of Families for Children's Mental Health. (n.d.) Retrieved October 24, 2006 from <http://www.ffcmh.org>

¹⁵ New York City Department of Juvenile Justice. (n.d.) *A career as a juvenile counselor*. Retrieved October 23, 2006 from <http://www.nyc.gov/html/djj/html/counselor.html>

¹⁶ MedicineNet.com: We Bring Doctors' Knowledge to You. (n.d.) *Licensed clinical social worker definition*. Retrieved October 23, 2006 from <http://www.medterms.com/script/main/art.asp?articlekey=15160>.

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Note: According to the West Virginia Chapter of the National Association of Social Workers the following is a more accurate definition of Social Workers in order to more consistent with the federal Medicare definition.

Clinical Social Worker: An independently licensed professional with an accredited graduate degree in social work and additional specialized supervision and experience who may assess, diagnose and treat mental and emotional disorders.

Social Worker: A person with an accredited degree in social work who helps individuals, couples, families, groups, communities and/or institutions deal with a variety of issues and problems to improve overall functioning. An accredited social work degree program involves, at minimum, the study of human growth and development, mental health theory and practice, human behavior in the social environment, community organization, and research methods.

SECTION 2: MEASURES OF THE QUALITY FOR BEHAVIORAL HEALTH SERVICES INTEGRATED WITH PRIMARY CARE

Recommended Measures for Overall Quality of Behavioral Health

Domain	Outcome	APS/BHHF Status	Source of Data	External Requirement
Reduced Morbidity	<ul style="list-style-type: none"> MH= decreased symptoms SA= abstinence from drug/alcohol use 	Currently Measured	CareConnection® Data	SAMSA
Employment/Education	Adult employment status & youth school attendance	Currently Measured	CareConnection® Data	SAMSA
Crime and Criminal Justice	Decreased criminal justice involvement	Currently Measured	CareConnection® Data	SAMSA
Stability in housing	Type and stability of current housing	Currently Measured	CareConnection® Data	SAMSA
Social Connectedness	<ul style="list-style-type: none"> Increased social support Client reporting positively about social connectedness 	Will now be measurable	CareConnection® Data	SAMSA
Access/Capacity	Increased service capacity	Currently Measured	CareConnection® Data and Claims data from MMIS (Molina/Unisys)	SAMSA
Retention	<ul style="list-style-type: none"> SA= increased retention in treatment MH= Reduction in utilization of inpatient psychiatric beds 	Partially measured	CareConnection® Data and Claims data from MMIS (Molina/Unisys)	SAMSA

Perception of Care	Client's perception of care	Currently measured for youth only	YSS and YSS-F completed by APS	SAMSA
Cost Effectiveness	Average cost	Currently measured	Claims data from MMIS (Molina/Unisys)	SAMSA
Use of Evidence-Based Practices	Total Number of evidence-based programs and strategies	Technical Assistance Stage	BHHF	SAMSA
Medication Management	Antidepressant Medication Management	Measured annually from claims data	CareConnection® Data and Claims data from MMIS (Molina/Unisys)	HEDIS
Medication Management	Follow-up care for children prescribed ADHD Medication (ADD)	Measured annually from claims data	CareConnection® Data and Claims data from MMIS (Molina/Unisys)	HEDIS
Care Coordination	Follow-up after hospitalization for mental illness	Measured annually from claims data	CareConnection® Data and Claims data from MMIS (Molina/Unisys)	HEDIS